Prevention and Access Task and Finish Group Report

Children and Young People's Mental Health and Wellbeing Taskforce

This report summarises proposals from the 'Prevention and Access' Task and Finish Group of the Children and Young People's Mental Health and Wellbeing Taskforce and has informed the report *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing.* **It is not a statement of Government policy.** A full list of members and contributors is included at the end of the report.

Contents

Introduction

1. The objective of the Prevention and Access Task and Finish Group was to identify ways of implementing effective, evidence-based mental health promotion and prevention and improving access to timely evidence-based support for children and young people whatever their mental health needs. This covers all access points including primary care and hospitals, early years settings, schools and colleges, social care, youth justice the voluntary and community sector, and other agencies that children and young people come into contact with. It encompasses the journey from first-point-of-contact services through to targeted and specialist services. It includes services for children and young people in crisis and those making the transition to adult services or other services during their care path. The scope covers children and young people from 0-18, as well as consideration of transition to adult services or other services during their care path and the potential to develop age/developmentally appropriate services for up to age 25. It also includes addressing the stigma associated with mental health problems and the stigma associated with accessing mental health care/services.

2. **The work of the group was divided into three themes:**

   - **Improving mental health promotion and prevention** (mental health/healthy minds promotion and prevention and early identification of mental health problems across the 0-18 age range)

   - **Improving access – providing the right support at the right time by appropriately skilled professionals** (including evidence-based interventions, national access and waiting time standards, care pathways and transitions)

   - **Training to deliver improved mental health promotion, prevention and evidence-based interventions and support** (across the children's and young people's workforces)

The vision

3. The vision that has emerged from the group is to have continuity of care for children, young people and their families. This includes prevention, early intervention, diagnosis, treatment and recovery which recognise both parity of esteem between, and integration of, physical and mental health, as well as the importance of timely flexible and evidence-based responses to children and young people and their families' needs. This vision is child and young person-centred and largely community based. It is a transparent system which everyone understands how to use and the planning of which is informed by the needs and preferences of children, young people and their parents/carers.

The case for change

The needs of the nation

4. Over a quarter of a million children and their carers attend statutory CAMHS, and there are over 3,000 child and adolescent psychiatry admissions to hospitals each year[1]. These figures relate to specialist NHS services and do not include the hundreds of thousands of children accessing mental health support in the community, through school, or via telephone helplines.

5. The number of children and young people in treatment is thought to represent only a fraction of the total that need it. It is estimated that around three quarters of children and young people with a clinically significant mental health disorder are not in touch with appropriate mental health services. Added to that are the many children and young people with lower level distress whose problems often remain overlooked and unaddressed, and those who are prevented from accessing help by the strong and prevalent stigma that exists around mental health problems. As such, there are hundreds of thousands of children and young people in the UK who may be experiencing mental distress and suffering. The human case for striving to reduce this distress and suffering is overwhelming – let alone the economic and resourcing arguments detailed below.

Failure to invest, failure to save

6. Child and adolescent mental health problems are costly, with the annual short-term costs estimated at £1.58 billion and the annual long-term costs estimated at £2.35 billion[2].

7. As childhood emotional and behavioural problems are associated with such a wide range of adverse outcomes (including educational underachievement, unemployment, crime and violence), costs affect not just child and adolescent mental health services, but many other services including education, social care, youth and criminal justice, adult health, and welfare. As just one example, the total annual social care costs for mental disorder across children and young people aged 5-15 in England are calculated at £67 million[3].

8. Investments can be cost-effective, with cost-benefit analyses of early intervention services showing an average return of over £3 for each £1 spent[4], with some interventions generating a return of up to £83 of benefits for each £1 spent[5].

9. However, savings from prevention and intervention tend to benefit areas that did not make the initial investment. For example, for every £1 spent on effective school counselling

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[1] NHS England (2013). 2013/2014 NHS standard contract for tier 4 CAMHS.

[2] Strelitz, J. (2012). The economic case for a shift to prevention. Annual Report of the Chief Medical Officer 2012 – Our Children Deserve Better: Prevention Pays.

[3] Strelitz, J. (2012). The economic case for a shift to prevention. Annual Report of the Chief Medical Officer 2012 – Our Children Deserve Better: Prevention Pays.

[4] Barnardos (2012). The Value of Early Intervention.

[5] Knapp et al (2011). Mental health promotion and mental illness prevention: the economic case.

services, there is a cost saving of £6 which includes reduced costs associated with social services, welfare benefits and the criminal justice system[6].

10. Failure to offer effective intervention until a late stage when mental health problems are already entrenched contributes further to the costly burden of mental health problems. The financial returns on investments are highest for years 0-3, and diminish progressively with age[7]. Failure to invest in timely prevention and early intervention at any age allows acute conditions to develop into chronic ones, leading to higher short-term and long-term costs across sectors.

Increased demand, pressured services, obscured access

11. Whilst having to deal with funding cuts and decreased resources, child and adolescent mental health services have also seen a marked increase in the number and complexity of referrals at a moderate to severe level of mental health difficulties[8]. This has had three major consequences:

- Waiting lists build up a large backlog, resulting in long and distressing delays for children and young people and their parents/carers who need help but for whom the system is failing to provide appropriate support at the right time. Figures from 2013/2014 show that the mean average of maximum waiting times for Tiers 1 – 3 routine appointments was 21 weeks; this reflects an ongoing annual increase, up from 15 weeks in 2012/2013 and from 14 weeks in 2011/2012 [9].

- The existing lack of clarity around referral processes and pathways is further complicated by treatment thresholds either tightening or unpredictably shifting according to the resources available, leading to confusion amongst GPs, schools, and other sources wanting to make referrals.

- Specialist services need to prioritise the most risky, severe problems and are not able to see children and young people at an earlier stage. It also impacts on the provision for services at other levels, meaning that less resource is available for preventative and early intervention services which, when combined with increased thresholds for specialist intervention, allows mental health problems to escalate to heightened levels of severity. Failure to provide timely early interventions thereby contributes further to demand.

Summary of key proposals

12. **Proposal 1: Create a national movement to dispel stigma and promote awareness of positive mental health and emotional wellbeing, as well as a better understanding of mental health problems, what support is available and how to access support (a 'national movement for change') through:**

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[6] Place2Be (2014). What is the social value?

[7] Heckman, J.J. (2008). School, skills, and synapses. Economic Inquiry, 46(3), 289-324.

[8] Kurtz, Z. (2009). The Evidence Base to Guide Development of Tier 4 CAMHS. Department of Health, Gateway Reference Number 11925.

[9] NHS Benchmarking Network (2014)

- A national branded campaign focused on both reducing stigma and promoting access to support, designed and directed in collaboration with children, young people and their parents/carers, promoted through a range of media and across universal settings and building on the existing Time to Change anti-stigma campaign.

- Information about promoting good mental health for children, young people and families and how to recognise the signs of mental health problems as well as what can be done to help, provided through a national website, for example by adapting and extending MindEd to parents/carers, children and young people.

- A nationally branded web-based portal to enable children, young people and parents/carers to access information and support on mental health problems, accessible through NHS choices. This would point children, young people and parents/carers in the right direction of high quality and reliable online resources and full contact details for local services, rather than providing online therapy itself.

13. Proposal 2: Develop an inclusive life course approach to mental health and emotional wellbeing from the earliest years, through the school-age years and transition to adulthood, by:

- Ensuring full delivery of the commitments in the mandates with NHS England and Health Education England, by working to increase specialist perinatal mental health provision, to reduce the incidence and impact of postnatal mental illnesses, and to update training for health visitors and midwives.

- Ensuring full implementation of the Healthy Child Programme (0-5 and 5-19) across England, making the best use of midwifery services, health visitors, schools nurses, Sure Start Children's Centres and primary healthcare services to identify families in need of additional support and to deliver evidence-based interventions.

- Encouraging all schools to continue to develop whole school approaches to promoting mental health and emotional wellbeing in education, including building on the Department for Education's current work on resilience, Personal, Social, Health, and Economic (PSHE) and counselling services in schools. This Task and Finish group proposes creating an expectation that secondary schools provide counselling services, supported by quality standards. While counselling services within schools are not intended as a substitute for other community and specialist mental health services, they can be a valuable complement to them, and schools should be supported to make appropriate referrals to specialist support when needed.

- Promoting best practice in transitions between services in which transition takes a flexible approach based on individual circumstances, with joint working and shared practice between services. For transitions to adult services, this should include flexibility around age boundaries.[10]

14. Proposal 3: Establish clearly identifiable access points into the system, including:

- Development of single point of access arrangements, learning from the co-commissioning pilots and the CYP IAPT programme.

- Greater use of one-stop-shop models particularly for early intervention and targeted support as a core part of any universal local offer, backed up by adequate investment.

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[10] For guidance see http://www.england.nhs.uk/resources/resources-for-ccgs/

- An identifiable, dedicated contact point in specialist CAMHS for educational establishments and primary care providers to discuss referrals, provide consultation and liaison (an enhanced model could include specialist CAMHS therapists who work directly in schools/GP practices with children, young people and families).

- A specific individual identified as holding responsibility for mental health in schools, to provide teachers and support staff with an initial point of referral and advice to discuss concerns about individual pupils, and to promote whole school approaches to mental health and wellbeing.

15. **Proposal 4: Proposals around improving access need to be matched by sufficient commitment to provision of targeted and specialist services**. **Between 2015 and 2020 we need to see significant (incremental) improvements in access and waiting times to targeted and specialist services backed up by:**

- A prevalence target underpinning a commitment to provide sufficient resource to allow an increasing proportion of children and young people with mental health needs to be treated.

- Access and waiting standards based on both time taken from request for help and referral to assessment, and time taken to access evidence-based treatment.

- Sufficient funding to deliver the expansion of services needed, as improving waiting times and increasing the proportion of children and young people who receive treatment is reliant on services' resources and capacity to achieve this.

16. **Proposal 5: Require a lead commissioner (working with local partners) to produce a local offer, which sets out to local people what support is available and how to access universal, targeted and specialist services.**

- Design and implementation can be informed by the experience of developing special education needs and disability (SEND) local offers, recognising the importance of an offer that is seamless to the individual, focused on improving outcomes, and designed in partnership with families and young people from the outset.

- This links closely to the proposal from the Co-ordinated System Task and Finish Group that the current system should be re-modelled into one that is simpler, more coherent and that draws together statutory and voluntary organisations into a single integrated and jointly commissioned system, backed by an increase in investment in services so that support is available to meet identified mental health needs.

- The local offer needs to be co-ordinated with the commissioning of Tier 4 CAMHS services by NHS England to develop effective care pathways.

- The local offer must include adequate provision of a multi-agency response for children and young people in crisis.

17. **Proposal 6: Develop the skills of the children and young people's workforces across all sectors to effectively support, identify and refer children and young people who may have mental health problems, and to promote good mental health, by:**

- Addressing core content of initial teacher training and quality of CPD. The Carter Review of Initial Teacher Training[11] reported in January 2015. It recommended

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[11] https://www.gov.uk/government/publications/carter-review-of-initial-teacher-training

commissioning a sector body to produce a framework of core content for ITT, which would include child and adolescent development.

- Addressing gaps in initial training and CPD for nurses, GPs, and paediatricians. Training should be reviewed and updated to promote shared training with specialist practitioners and enable nurses, GPs, and paediatricians to gain broader mental health exposure.

- Developing a workforce strategy for staff within targeted and specialist mental health services, to ensure that staff have the right skills to assess and formulate children and young people's problems, offer access to treatment based on evidence-based approaches, and recognise the limits of their expertise. To achieve this, this Task and Finish group proposes the continuation and expansion of CYP IAPT training for professionals (including community and schools-based staff such as counsellors and school nurses).

Improving promotion of emotional wellbeing and prevention of mental illness

"Without the correct interventions and support at this age, they will go on to be vulnerable adults who struggle to take their rightful place in the world. And that costs society far more than earlier intervention would."

A parent who took part in the Taskforce engagement exercises

Mental health promotion

18. Mental health promotion involves actions to increase the chances of more people experiencing better mental health, by creating living conditions and environments that allow people to adopt and maintain behaviours and lifestyles that support good mental health[12]. We need to recognise the **importance of recognising and promoting good mental health and wellbeing in everyone**. Action should be universal, as well as targeted. Despite the applicability of mental health promotion to every single person in the population, spending on mental health promotion in England is estimated at less than 1% of all NHS and local council expenditure on mental health[13]

19. Bronfenbrenner's Ecological Model indicates the many aspects of the environment that can have an impact on the child and his/her development, ranging from his/her immediate family, siblings, peers and immediate educational setting through to the wider environment including the neighbourhood, communities, parents' work environment, extended family and mass media and the wider environment beyond that including the socio-economic and political, cultural and legal contexts. These factors can interact with each other (see Chief Medical Officer Report 2013, Figure 6.1) and are also influenced by a range of socio-historical patternings and conditions. Mental health promotion can take place at all or any of these levels, and should draw on the expertise of children and young people themselves, as well as their family/parent/carers.

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[12] WHO (2014). Mental health: strengthening our response. Fact sheet no. 220

[13] Mental Health Strategies (2006). National survey of investment in mental health services.

Enhanced support to parents

20. **Preventing the development of mental health problems starts before birth.** There is a strong link between parental (particularly maternal) mental health and children's mental health. Maternal mental health problems during and following pregnancy have been found to be a significant factor with the potential to adversely affecting the quality of mother-infant interaction, with negative consequences in terms of children's behavioural and socio-emotional development. Optimising maternal mental health during and following pregnancy therefore needs to be given the same emphasis as optimising maternal physical health. Universal services including Sure Start Children's Centres and health visitors have a crucial role to play in this, as well as in facilitating access to Perinatal and Infant Mental Health Services where early issues are identified. Important recent developments include the mandate to Health Education England: by 2017 every birthing unit will have access to a specialist perinatal mental health clinician; the Institute for Health Visitors is updating training given to all health visitors around mental health; and DH is working with maternal mental health alliance to design training programmes for midwives. Nonetheless, despite some excellent examples of high quality service provision, at present there is an unacceptable variation in the assessment and provision of perinatal and postpartum mental health services. Members of this Task and Finish group support the creation of an expectation for primary care services to include the routine use of validated perinatal mental health indicators and ease of access to maternal mental health support, provided by suitably qualified professionals.

21. Members of this Task and Finish group support the full implementation of the NICE guidelines on antenatal and postnatal mental health (CG45), which include the routine assessment of the mental health of all pregnant and postpartum women at a primary care level, to ensure that they are given appropriate support at the earliest opportunity. The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth. Members of this Task and Finish group endorse these recommendations and further propose that to supplement this, HEE establish a minimum standard of training in perinatal mental health at a pre-registration level for midwives and health visitors. Some members of this Task and Finish group further propose that parental mental wellbeing awareness be integrated into antenatal classes (eg Preparation for Birth and Beyond groups) and employer's occupational health support on return from maternity leave.

Enhanced promotion and prevention in the early years

"It's too late, starting at 18… you need to get it when it starts and when you can actually address the problem… so you should start much younger."

A young person who took part in the Taskforce engagement exercises

22. This Task and Finish group recognises the crucial importance of the early years as a foundation of healthy development and positive physical and mental health, and acknowledge the cost-effectiveness of acting as early as possible. Members of this Task and Finish group fully endorse the principles and strategies set out in the Healthy Child Programme (HCP) 0-5 years and NICE guidance 'Social and emotional Wellbeing: The early years' (CG40). A key component of the Healthy Child Programme is supporting parents/carers to develop a positive early attachment with their infant. **Members of this Task and Finish group propose that take-up of the Healthy Child Programme should be increased across England,(for example measured through data that will become available from 2015 on take-up of the two year old check) and its implementation**

reported on. Members of this Task and Finish group also propose that Public Health England's rapid review of the evidence base for the HCP be used as an opportunity to help local services make use of the most up-to-date evidence.

23. Both the HCP and NICE guidance recommend the provision of methods of supporting early parenting and attachment (eg skin-to-skin contact and video feedback[14]) for both mothers and fathers within the context of universal services (eg midwifery and health visiting). They recommend the use of such universal-level services to identify families who are in need of additional support using techniques such as health needs assessments, antenatal preparation, and postnatal promotional interviews. There is also consistently strong evidence to support the use of interventions such as home visiting programmes (eg Family Nurse Partnership) during the perinatal period. Public Health England fully supports this approach and will continue to be responsible for maintaining the quality of delivery of Family Nurse Partnerships as well as continuing to work with Local Authorities to promote the universal delivery of health visitor services.

24. HCP and NICE also recommend the use of a range of targeted methods of working to promote early attachment and positive parenting methods more generally. A review of attachment-based interventions showed that they are effective in improving parental sensitivity and infant attachment security. In addition to showing significant long-term effects across a range of parental and child outcomes[15], parenting interventions are also cost-effective. For example, Parent-Child Interaction Therapy is estimated to save £2.37 for every £1 spent, and the Triple P Positive Parenting Programme is estimated to save £5.05 for every £1 spent[16]. Parenting interventions can also act to reduce health inequalities. For example, the Incredible Years programme delivers larger effects for more severe problems[17].

25. **Members of this Task and Finish group endorse the NICE Guidance Social and Emotional Wellbeing in Primary Education and the Healthy Child Programme as the strategy for mental health promotion of children aged 5-12 and propose its full implementation across England.** As detailed in the Chief Medical Officer Report 2013 (Chapter 7), an assets-based approach strengthening protective factors or health assets in schools, in the home and in local communities can make an important contribution to reducing risk for those who are vulnerable and in so doing promote their chances of leading healthy and successful lives.

Enhanced promotion and prevention in adolescence

26. Members of this Task and Finish group acknowledge that promotion and prevention work maintain their importance across different ages, and should be applied to adolescent years

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[14] Law, J., Plunkett, C., Taylor, J., Gunning, M. (2009) Developing policy in the provision of parenting programmes: integrating a review of reviews with the perspectives of both parents and professionals. Child Care Health and Development, 35(3): 302-312

[15] Sanders, M.R., Kirby, J.N., Tellegen, C.L., Day, J.J (2014). The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. Clinical Psychology Review, 34(4): 337-357

[16] Early Intervention Foundation (2014). Making an Early Intervention Business Case: Evidence and Resources.

[17] Menting, A., de Castro, B.O., Matthys, W. (2013). Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behaviour: A meta-analytic review. Clinical Psychology Review, 33(8): 901-913

in addition to early years and childhood, particularly as the majority of mental health problems begin to manifest in adolescence. Therefore, promotion and preventative action at this stage in the life course are vital. There are good examples of programmes that can be applied across different stages of youth, such as parenting programmes. For example, the Triple P Positive Parenting Programme is delivered to parents of children up to 12 years, whilst the Teen Triple P Positive Parenting Programme is delivered to parents of 12 to 16 year olds. There are also good examples of prevention programmes specifically targeted towards at-risk adolescents, such as the schools-based PreVenture programme[18], which has been shown to effectively prevent common emotional problems alongside reducing teenage substance misuse and other risky behaviours.

27. Adolescence is known to be a period where the risk of self-harm increases and suicide is one of the leading causes of death in young adults; therefore youth is a prime period in which to take action to protect against this. Interventions that successfully reduce adolescent suicidal risk commonly have a focus on augmenting family cohesion and improving the quality of relationships between young people and their parents[19], both of which are protective against suicidal behaviour.

28. Promotion and prevention programmes delivered in educational settings can also be effective for preventing suicidal ideation and behaviour by raising mental health awareness, screening for those at risk, and promoting peer understanding and health-seeking behaviours amongst adolescents. There are a number of different school programmes that have shown effectiveness in this area (eg Signs of Suicide, Gatekeeper Training, the Good Behaviour Game, Youth Mental Health Awareness Training)[20][21][22].

Empowering, educating, and reducing stigma

"I think it is very important that young people know how to recognise issues concerning mental health. There also needs to be less of a stigma associated with mental health. Both of those things deterred me for a long time from receiving the help I needed."

A young person who took part in the Taskforce engagement exercises

29. Members of this Task and Finish group support the **education and empowerment of children and young people and their families** as strategies for promoting mental wellbeing, preventing mental ill-health, and addressing the existing stigma associated with mental health problems. Children, young people and their parents/carers need clearer awareness of what it is to have good mental health and poor mental health, as well as better information about how to keep themselves and each other mentally and emotionally healthy.

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[18] http://www.kcl.ac.uk/ioppn/depts/addictions/research/legacyprojects/PreVenture.aspx

[19] Brent, D.A. et al (2013). Protecting Adolescents From Self-Harm: A Critical Review of Intervention Studies. Journal of the Academy of Child & Adolescent Psychiatry, 52(12): 1260-1271

[20] Katz, C., et al. (2013). A review of school-based suicide prevention programmes. Depression and Anxiety, 30(10): 1030-1045

[21] Robinson, J., et al. (2013). A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behaviour in young people. Crisis – The Journal of Crisis Intervention and Suicide Prevention, 34(3): 164-182

[22] Wasserman, D. et al. (2012) Suicide prevention for youth – a mental health awareness program: lessons learned from the Saving and Empowering Young Lives in Europe (SEYLE) intervention study. BMC Public Health, 12: 776

The members of this Task and Finish group advise that to reduce stigma, the language used in delivering this information needs to be "wellness" orientated as well as "illness" orientated, with the overarching message that anyone can experience difficulties, may need additional help at times, and that recovery is possible.

30. This Task and Finish group suggests the creation of a **national 'branded' campaign focused on both promoting good mental health and reducing the stigma surrounding mental illness,** designed and directed in collaboration with children, young people and their parents/carers, and promoted through a range of media and across universal settings (eg schools, youth clubs, libraries, GP surgeries, pharmacies, hospitals) in order to optimise the reach of information. The campaign could build on the interest and engagement of young people generated through the PHE-led 'Rise' initiative and could take a similar form to the Change 4 Life or Talk to Frank campaigns, or it could be an extension of the existing Time to Change anti-stigma campaign, the awareness of which has been associated with greater mental health literacy as well as less stigmatizing attitudes[23].

31. The campaign could focus on giving exposure to people with experiences of mental health problems and recovery (eg peer talks by children and young people, celebrity endorsements of accessing help) which has been shown to yield significantly better effects than education alone [24]. It should also directly consult with children and young people for their views on using **innovative approaches** (eg social media, storylines embedded in television programmes, community advocacy services, etc) in order to make the subject more interesting and motivate children and young people to find out more.

Supportive schools and colleges

"Schools need to be much more aware and much better equipped to deal with mental health issues because young people spend most of their time at school, so it makes sense for those places to be the most alert to catch these mental health problems before they become more serious."

A young person who took part in the Taskforce engagement exercises

32. Our consultation with children and young people has shown that they believe educational settings have a key role to play in maintaining their mental health and emotional wellbeing[25]. Early years settings, schools and colleges play a particularly vital role in ensuring children and young people's wellbeing through delivering mental health promotion and prevention activities, which work best when they operate on a whole-system basis. Members of this Task and Finish group propose that schools (and colleges) should be supported to implement NICE guidance on social and emotional wellbeing in education[26] and to **continue to develop evidence-based whole-school approaches towards mental health and emotional wellbeing**. This should incorporate strong leadership from senior management in

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[23] Evans-Lacko et al (2013), Influence of Time to Change's social marketing interventions on stigma in England 2009-2011. British Journal of Psychiatry 2012:77-88

[24] Corrigan et al (2012), Challenging the public stigma of mental illness: A meta-analysis of outcome studies. Psychiatric Services, 63:963-973

[25] YoungMinds (2014) Report on Children, Young People and Family Engagement for The Children and Young People's Mental Health Taskforce

[26] NICE (2008). Social and emotional wellbeing in primary education. London: NICE
NICE (2009). Social and emotional wellbeing in secondary education. London: NICE

championing mental and emotional wellbeing[27], support for all staff, sharing of best practice, and strong links to the wider community.

33. The vast majority of secondary schools surveyed in recent CentreForum research[28] reported that they implement programmes to promote positive mental health universally across the student population, with 93% doing this within the context of PSHE education. The research also indicates that pupils in 86% of secondary schools surveyed have access to a trained/qualified counsellor(s), and almost all secondary schools (98%) have pastoral care services.

34. The Department for Education (DfE) is leading work to improve the quality of teaching about mental health within PSHE lessons in schools, and has commissioned the PSHE Association to produce guidance for schools in teaching about mental health safely and effectively, which will be available in spring 2015.

35. Some members of this Task and Finish group also propose that as part of developing whole school approaches, emotional wellbeing promotion and mental health education be delivered to more children and young people through making PSHE lessons statutory.

36. Inspection is also a key lever to drive improvement. The new draft Ofsted inspection framework 'Better Inspection for All' includes a judgement on personal development, behaviour and welfare of children and learners.

37. Young people may have an important role in informing and supporting other young people about mental health prevention and access. Consultation with young people has shown that they expressed the desire to hear from other young people who have accessed mental services[29]. Peer support schemes should be led and design by children and young people themselves, with careful professional support to reduce risk both to peer mentors and the young people they are involved with. For bullying, research indicates that peer support schemes can help victims feel more positive about themselves, are beneficial to the peer supporters themselves, and may also contribute to a safer and more caring school environment[30] [31].

Case Study: Promoting positive mental health and emotional wellbeing through PHSE at St Marylebone CE School

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[27] Durlak, J.A. and DuPre, E.P. (2008) Implementation matters: a review of research on the influence of implementation on program outcomes and the factors affecting implementation. American Journal of Community Psychology, 41: 327-350

[28] Taggart, Lee and McDonald (2014): Perceptions of wellbeing and mental health in English secondary schools: a cross sectional study. CentreForum Commission.

[29] YoungMinds (2014) Report on Children, Young People and Family Engagement for The Children and Young People's Mental Health Taskforce

[30] Anastasio Ovejero Bernal, Santiago Yubero Jimenez & Peter K. Smith (Eds) Conductas de Violencia Escolar: Perspectivas Internacionales. Biblioteca Nueva. Adapted and updated from Cowie, H. & Smith, P.K. (2010).

[31] Peer support as a means of improving school safety and reducing bullying and violence. In Doll, B., Pfohl, W., & Yoon, J. (Eds.). *Handbook of Youth Prevention Science.* New York: Routledge, pp.177-193.

The St Marylebone CE School in Westminster makes use of the curriculum throughout the whole school to promote mental health and well-being. Students explore the idea of 'being healthy' and are taught that mental health is as important as physical health. The PSHE curriculum includes the promotion of self-esteem, independence and personal responsibility and looks at topics such as work-life balance, stress management and healthy relationships. The PSHE curriculum is also delivered through off timetable 'well-being days' and a cross curricular week with specific sessions to raise awareness of mental health. Teachers are supported to deliver practical sessions about mental health issues, the importance of sleep and practical relaxation techniques such as Yoga and Meditation. The school also has a 'thought for the day' in which students are read anecdotes, news items and parables to encourage contemplation on issues of morality and their own personal growth.

Improving access – providing the right support at the right support at the right time by appropriately skilled professionals

"[I would like] shorter waiting times, a choice in who you see and where you access a service, useful support whilst on waiting lists, better information nationally on WHERE to go, WHO you will see and WHAT support looks like."

A young person who took part in the Taskforce engagement exercises

Empowerment through information

38. Children and young people have highlighted information as a key issue in accessing mental health services, expressing the desire for more information about mental health, where and how to access mental health services, and what to expect from these services[32]. Children, young people and their parents/carers need clearer awareness of how to recognise when they might have a mental health problem as well as where and how to get help, what might happen when help is accessed, and what to do whilst they are waiting. Information for parents/carers makes all the difference in helping their children to access mental health services, with parental attitudes about mental health and the extent to which care matches their expectations, having more of an effect on their child's access of services than concrete barriers such as transportation[33]. All places where children and young people go to for support with mental health should comply with the Department of Health's 'You're Welcome'

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[32] Plaistow, J. et al (2014). Young people's views of UK mental health services. Early Intervention in Psychiatry, 8: 12-23.

[33] Bannon, W.M. & McKay, M.M. (2005). Are barriers to service and parental preference match for service related to urban child mental health service use? Families in Society – the Journal of Contemporary Social Services, 86(1): 30-34

quality criteria for youth-friendly health services[34] and the 'Delivering With, Delivering Well' values and standards developed under the CYP IAPT programme[35].

39. **Digital resources** can act as useful sources of mental health information and support[36], particularly during the waiting period for face-to-face treatment as well as for socially isolated children and young people. The use of apps and other digital tools can empower self–care, giving children and young people more control over their health and wellbeing and empowering their parents and carers. In this way, on-line support can be complementary, but not an alternative to face-to-face support. Our consultation with children and young people has shown that the internet is commonly recognised as a place to turn to for advice and information on mental health but highlighted the importance of being reassured (through a quality kite-mark) that the web information is reliable, accurate and updated by a trusted source[37]. Harnessing the potential of the web to promote resilience and wellbeing aligns with the principles set out in *Personalised Health and Care 2020*[38] and the priority it has already given to young people. In addition to information about mental health and mental health services, it is equally important to provide children and young people with advice about the options available to them, their rights to consent, and their rights to confidentiality.

40. This Task and Finish group makes the following proposals:

- **Provide information about recognising the signs of mental health problems and advice on options and rights for children, young people and families through a national website**, for example by adapting MindEd in collaboration with parents/carers, and then with children and young people, to extend MindEd to these groups. This would provide a national coverage of information about mental health issues in an engaging and reliable format; and is a fairly 'quick win'.

- **Develop a national branded web-based portal to enable children, young people and their parents/carers to access safe and reliable information and support on mental health, accessible through NHS Choices.** This would point children and young people and parents/carers in the right direction of high quality and trustworthy online information and self-help resources, rather than providing online counselling itself. It could include a sign posting/postcode search function, and build on existing websites such as My CAMHS Choices http://mycamhschoices.org/ or the Youth Wellbeing Directory http://www.youthwellbeingdirectory.co.uk/.

- **Consider the use of online psychological therapies/counselling services by local commissioners.** Online counselling support is best commissioned locally to take account of the needs and diversity of the local population and to wrap around other services including face to face counselling/psychological therapies. Some local areas already do this successfully. Local online services might be

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[34] Department of Health (2011). Quality criteria for young people friendly health services. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

[35] http://www.england.nhs.uk/wp-content/uploads/2014/12/delvr-with-delvrng-well.pdf

[36] Borzekowski et al (2009). Use of the Internet and Other Media for Health Information Among Clinic Outpatients with Serious Mental Illness. Psychiatric Services, 60(9): 1265-1268

[37] YoungMinds Engagement Activity (2014)

[38] National Information Board (2014). Personalised Health and Care 2020: using data and technology to transform outcomes for patients and citizens.

supplemented by national apps such as eCBT apps, but national apps would be of limited effectiveness if not clearly linked into locally commissioned services and at the present time there is limited evidence as to the effectiveness of such models.

- **The National Information Board works with the Government Digital Service, NHS Choices, and young people themselves to develop a framework for harnessing the power of digital technology and protecting young people from mental harm.** This could include incentivising the development of new apps and digital tools, and the possibility of a kite-marking scheme based on research evidence in order to guide young people and their parents/carers in respect of quality and safety.

- **Additionally, it should be standard for young people and their parents/carers to be signposted to online information during the wait for access to face-to-face support.** These online resources should complement rather than replace other resources.

41. By developing a culture of viewing children and young people as partners in the maintenance of their mental health, we can enhance the work of the professional workforce. This would mean enabling children and young people to enjoy a degree of control in taking responsibility for their mental health, and facilitating a feeling of self-reliance which becomes increasingly valued by young people as they grow older and become more independent and autonomous. This requires service providers to be responsive to the wishes and preferences of young people – for example, by offering them choice and working collaboratively with respect to all aspects of their care , including mode of treatment, practitioner, timing of appointments, location of appointments, and means of communication[39]

42. Parents/carers are vital to maintaining their child's mental health and should be kept involved and informed and given information on how best to support their child. With this approach, care needs to be taken regarding the young person's confidentiality; the wishes of the competent young person should be respected and given priority for as long as this does not compromise their safety or that of others. In some cases, where difficult family dynamics may be part of the picture of the young person's difficulties, partnership work with parents/carers may need to be of a different order. In addition there are problems such as early onset eating disorders and conduct disorder where family work is the most effective intervention. Parents/carers who have mental health problems themselves should also be signposted to additional appropriate support and co-ordinated working between adult and child services can help to facilitate integrated care in order to meet the needs of the family.

43. **Members of this Task and Finish group propose that all commissioned CAMHS services should ensure their support offer includes that every child or young person accessing a mental health intervention is treated as a 'partner in care' and offered support,** for example provision of appropriate information about a mental health problem, self-support resources, and guidance on day-to-day coping in between appointments with professionals. The 'partner in care' approach should be extended to parents/carers except where the young person does not consent. In cases where a young person does not agree to specific information being shared with their parents/carers, it may still be possible to

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[39] Plaistow, J. et al (2014). Young people's views of UK mental health services. Early Intervention in Psychiatry, 8: 12-23

provide more general information to the parents/carers to enable them to support their child. Children and young people and parents should have confidentiality explained to them as well preferences explored for information sharing.

Establishing clearly identifiable access points to mental health care and support

"I would just like to see a change in how young people can access support easier. It is so hard trying to find it, let alone doing it."

A young person who took part in the Taskforce engagement exercises

44. Effective access to support requires improved communication between universal, targeted and specialist services, including early years settings, schools, colleges, LAs, primary care, social care, youth justice, voluntary sector services, and targeted and specialist CAMHS, backed by a clear shared understanding of roles and responsibilities across all those involved in the system, so that children and young people and their families (where appropriate) are able to receive timely and appropriate support and don't fall through the gaps between services.

45. Specific proposals from this Task and Finish group to develop clearly identifiable contact points within services and improved liaison between services include:

   a) **A dedicated contact point in specialist CAMHS for every educational establishment and primary care provider to discuss referral and management of cases, and provide timely consultation and liaison.**

      i) As a minimum this would involve professionals based primarily in CAMHS services offering a point of contact.

      ii) An enhanced model could include specialist CAMHS staff who work directly in schools/GP practices with children, young people and families. It is vital that children and young people are seen soon, once serious problems are apparent.

      iii) We need to develop a specification for what we think a dedicated contact point (or single point of access) and enhanced models would look like, how these might be funded/commissioned, linking to payment systems, and how these could be built around the needs of children and young people and their families.

      iv) Such a role would need to be supported by appropriate training and strong working relationships, with the development of a joint training programme for dedicated contact points, GPs, nurses, and school staff.

   b) **A specific individual(s) identified as holding responsibility for mental health in schools** (and possibly colleges), to co-ordinate activities and to provide other staff with a point of expertise to discuss concerns about individual cases. Consideration should be given to what would be realistic for the staff to focus on and prioritise, taking into account training requirements. Members of this Task and Finish group have suggested the role could include: improving awareness amongst school staff members about prevention and early identification; coordinating referrals to mental health services; implementing whole school provider strategies for mental health; and managing in-school provision of mental health services

   c) **Guidance for schools, GPs and other services on roles and responsibilities in relation to improving the quality of identification and referrals, as well as methods for doing so.** This would build on existing resources, including guidance already issued

by DfE on behaviour and mental health in schools.

d) Use and develop evidence to **establish a clear expectation about the access that all school pupils should have to effective counselling**, supported by quality standards. This would build on the DfE's development of an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools. Most secondary schools already provide access to counselling, and based on the current evidence we feel all secondary pupils should have that opportunity. A growing number of primary schools are providing access to counselling support, but the evidence is yet to be established for that age group. While counselling services within schools are not intended as a substitute for other community and specialist mental health services, they can be a valuable complement to them, including facilitating appropriate referral to external services according to need and working with children and young people referred to them by other services. See **Annex B** for more detail on school counselling.

   i) There is some indication: that young people believe that counselling should be provided in schools[40][41]; that more pupils express a preference for seeing a counsellor within a school context rather than outside of school[42]; and that schools with embedded mental health support produce a positive impact[43]. School based counselling services and specialist CAMHS would need to work in close partnership, both at a service level as well as in the case of individual children and young people. Alongside school counselling, we need to develop evidence-based psychotherapeutic provision for a range of difficulties. This would offer a degree of personalisation in choice of treatment, which should be based on the needs and preferences of the individual. This could include CAMHS workers operating directly in schools to offer evidence-based treatments, building on the above proposal to create named points of contact in specialist CAMHS for every school. It could also include making use of the existence of community-based providers that have solid experience in providing counselling and psychological interventions to school pupils.

46. Building on the previous proposals, this Task and Finish group proposes **promoting 'single points of access' arrangements to support early identification of need, timely assessment and formulation of difficulties, and prompt access to the right support at the right time by an appropriately skilled professional.** Wider use of a single point of access to mental health support should be a key part of local service arrangements, and can learn from co-commissioning pilots and those areas (such as Liverpool, Derby, and County Durham) that have already developed similar approaches. However, this Task and Finish group acknowledged that different areas have different needs, and that any system of access needs to be tailored to the diversity of the local population and its issues. The over-arching aim, therefore, should be that any arrangement should allow children, young people and their parents/carers to be provided with the means to be able to easily access a suitably

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[40] Fox, C.L. and Butler, I. (2007). 'If you don't want to tell anyone else you can tell her': young people's views on school counselling. British Journal of Guidance and Counselling, 35: 97-114

[41] YoungMinds Engagement Activity (2014)

[42] Quinn, P. and Chan, S. (2009). Secondary school students' preferences for location, format of counselling and gender of counsellor. Counselling and Psychotherapy Research, 9(3): 204-209

[43] Wolpert, M. et al (2011). Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011. Department for Children, Schools and Families.

qualified and experienced professional who will help them think about their problems and make sense of what's going on, explain the appropriate support options available and advise on their suitability, and assist with taking the case forward when necessary. This Task and Finish group has identified ten principles which are critical to the success of any single points of access system (see **Annex C**).

47. Members of this Task and Finish group have expressed a range of (often very supportive) views about **'one stop shop' models,** such as YIACS (Youth Information, Advice and Counselling Services) and Headspace (from Australia), which aim to reduce stigma by being based in the community and to increase take-up by providing access to a range of integrated services with a single point of entry which facilitates self-referral routes. Different models are open to differing client groups of children and young people (with differing needs) and we need to develop the evidence base on which approaches are most high impact/cost-effective within a UK context. This may not mean that <u>all</u> services are located in one building, but rather access routes are improved through universal services and specialist services working together, being adequately resourced, taking a 'no wrong door' approach and adopting person-centred principles.

- **In the short to medium term this Task and Finish group proposes an increase in the number of one-stop-shop services with more sustainable local funding for VCS providers, backed up by adequate investment in VCS-YIAC type services by LAs and CCGs (this links to proposals from the Co-ordinated System Task and Finish Group). In the longer term this could lead to one-stop-shop services becoming a key part of any universal local offer.**

- Models would require clarification of definition for consistency, whilst accepting there will be local variation – this could include physical health, public health, youth work, education, employment, and welfare rights aspects. There may be a case in future for developing national quality standards for a comprehensive one-stop-shop service, to ensure consistency.

- Models would need to be tailored to meet the needs of different sections of the local diverse population. This includes considering provision for different age ranges (possibly by including Sure Start Children's Centres) and for vulnerable groups, as well as considering viability in rural settings.

Commissioning a seamless pathway

"You have to fit into their paths and none of their paths fit you."

A young person who took part in the Taskforce engagement exercises

48. **This Task and Finish group proposes requiring a lead commissioner to produce a <u>local offer</u> - which sets out to local people what support is available and how to access services across universal, targeted and specialist services.** A clearly signposted 'pathway' of support would help to improve local understanding of what is, and what is not available across services/tiers (for further detail, please see the Co-ordinated System Task and Finish Group Report)

- Design and implementation can be informed by and strategically linked to the development of SEND local offers, recognising the importance of an offer that is seamless to the individual, focused on improving outcomes, and designed in partnership with young people and their families from the outset.

- This proposal would only be effective if combined with the proposals from the Co-ordinated System Task and Finish Group that the current system be re-modelled into

one that is built around the needs of children and young people and their families rather than the services provided - simpler, more coherent and draws together statutory and voluntary organisations into a single integrated and jointly commissioned system, backed by an increase in investment in services so that support is available to meet identified mental health needs.

- To facilitate ease of access, effective referrals, and improved communications, the local offer should include single points of access arrangements, dedicated contact points within targeted and specialist mental health services, and one-stop-shop services.

- The local offer needs to be co-ordinated with the commissioning of Tier 4 CAMHS services by NHS England, and informed by Tier 2 and 3 service specifications and Transitions specification which have been prepared by NHS England following consultation with young people, parents, providers and commissioners (see http://www.england.nhs.uk/resources/resources-for-ccgs/)

- The local offer must include adequate provision of multi-agency services and response for children and young people in crisis.

- The local offer should include a Perinatal and Early Years Strategy which sets out what support is available to local parents. This needs to be co-ordinated by the local council and CCG as part of the commissioning of the Healthy Child Programme and should outline the approach to targeted offers (eg Family Nurse Partnership[44]) as well as universal offers (eg Preparing for Birth and Beyond[45]).

- The local offer should be informed by locally relevant data that reflects the needs of the diversity of the local population. This could be facilitated by Health and Wellbeing Boards ensuring the inclusion of adequate intelligence on children and young people's mental health within Joint Strategic Needs Assessments (JSNAs).

- This proposal should be informed by consultation with, and active involvement of, children, young people, and parents/carers.

Investing in effective targeted and specialist community provision

"I managed to get better but as soon as I got discharged I fell back into a bad place and it's hard to access the support I need again."

A young person who took part in the Taskforce engagement exercises

49. **Investing in effective targeted and specialist community provision, including 'step down' provision with clear pathways for young people leaving inpatient care,** will help avoid unnecessary use of inpatient provision and can shorten duration of stay by easing the transition out of inpatient care. Whilst there are some young people who will always be best cared for within inpatient settings, the current lack of alternatives to admission and 'step-down' services mean many young people do not have an effective alternative to inpatient care. Absence or delays in the provision of services by health and social care can also result in delayed discharge, with children and young people continuing to remain in inpatient settings despite it no longer providing any benefit to them. This Task and Finish group

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[44] http://www.fnp.nhs.uk/about

[45] https://www.gov.uk/government/news/preparation-for-birth-and-beyond-resource-pack-to-help-parenthood-groups--2

proposes encouraging/piloting co-commissioning arrangements to implement clear pathways between inpatient and community care to prevent unnecessary admission and support 'step down' transitions and rapid intensive response for young people presenting with a crisis that are centred around the needs of the individual.

50. Greater use of community services in addition to stronger partnerships between CAMHS Tier 4, community based specialist services and local authorities, all closely linked to local strategic frameworks, could facilitate timely and good quality transfers out of inpatient care. Such services should be flexible enough to allow for the provision of intensive home-based treatment in cases for which the evidence base indicates that this is effective. All discharges from inpatient care should have a follow-up plan before discharge, including arrangement of assertive outreach and intensive treatment where needed within an appropriate time frame based on individual need. This would be particularly important for young people hospitalized for suicide attempt, for whom risk of recurrence is highest immediately following discharge[46]. Delays in transfers of care and discharge could be consistently monitored, reported on, and assessed. Establishing minimum standards for response times for children's social care would minimise delays in discharge where this is a factor.

51. As outlined in the NHS England CAMHS Tier 4 Report, a range of services available in the community are needed alongside inpatient services to provide safe and effective alternatives to admission, including:

a) Crisis assessment and crisis management services for children and young people in acute crisis, usually presenting with high levels of risk, which can provide both intensive community support in a crisis and prioritise admissions.

b) Intensive outreach services designed to facilitate pre-admission planning, early discharge, reduce lengths of stay, support transitions to other services and as a step down to enable embedding of interventions used in an inpatient setting in the home.

c) Planned intensive home treatment services for children and young people who need intensive long-term treatment, equivalent to that provided in an inpatient setting.

d) Specialist treatment services for example for children and young people with eating disorders or severe self-harm

e) Specialist services for children and young people with complex neurodevelopmental or neuropsychiatric difficulties and other disorders requiring specialist expertise beyond the level of Tier 3 CAMHS and for whom inpatient services are environmentally unsuitable.

Case Study: Community and Hospital Liaison in Derby City and County

Following a suicide attempt and admission to hospital 16 year old Zoe had to deal with suddenly going from 24-hour support to no support at all. Zoe and her family were given no information on where to find support in the case of future problems, but simply to get in touch with the GP if things got worse. They were not sure what "worse" meant, as Zoe felt that things were quite bad already. With no support around her, Zoe's problems quickly escalated once again and she found herself once more being admitted to an inpatient unit following another suicide attempt.

Derby City and County have a dedicated CAMHS liaison service that responds rapidly to all young people under 18 years old who present at the Royal Derby Hospital following significant

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[46] Ho, T.P. (2003). The suicide risk of discharged psychiatric patients. J Clin Psychiatry, 64:702-707;

Quin, P. and Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers. Archives of General Psychiatry, 62: 427-432

Inpatient care centred on the needs of children and young people

52. Where admission to an inpatient setting is needed, this should be as close to home as possible, taking into account the child or young person's individual needs. In cases that necessitate admission to a unit further away from home, parents/carers should be supported to be able to take an active part in their child's care and to maintain contact (unless there are strong reasons prohibiting this such as serious safeguarding concerns). Admission should be to an age appropriate setting avoiding the use of facilities for adults, unless this is in the young person's best interests and choice (for example, an individual aged over 17 who would rather be closer to home and who would rather not be in a unit with younger teenagers). Inpatient services should be high quality and part of peer review network, the Quality Network for Inpatient CAMHS. NHS England, in their review of Tier 4 services and the service specifications, has set out standards expected of all such services. It should be standard that for all children and young people who are admitted to inpatient settings proximity to home and the reasons for the choice of location recorded and monitored.

53. **Children and young people within hospital provision or inpatient units should have access to full-time education that is on a par with that of mainstream provision** and appropriately tailored where necessary to take account of their health needs, including appropriate support to meet the needs of those with special educational needs or disabilities. The NHS England service specification for Tier 4 services sets out an expectation that all such services should be OFSTED registered. The 2014 0-25 Special Educational Needs and Disabilities (SEND) Code of Practice sets out that the education provided must be suitable to the age, ability and aptitude, as well as to any special education needs a child or young person may have. This education must be full-time, unless the local council determines that, for reasons relating to the physical or mental health of the child, a reduced level of education would be in the child's best interests.

High quality crisis care

54. **For children and young people experiencing mental health crisis**, it is essential that they receive appropriate support / intervention as outlined in the Crisis Care Concordat, including a swift and comprehensive assessment of the nature of the crisis. This requires the provision of an out-of-hours mental health service that can respond to the needs of children and young people. At a service level there should be a multi-agency response bringing together NHS and local council children's services, as a mental health crisis often requires a multi-agency response with strong input from social care. A crisis or intensive response team should be resourced to respond to need immediately and offer intensive support in the home, community or in a place of safety if required.

55. Some members of this Task and Finish group believe there is a strong case for **legislating to ensure that no child or young person under the age of 18 would be detained in a police cell as a place of safety under the Mental Health Act section 136.** This requires there are sufficient alternative places of safety; there are a range of other possible places of

safety that can legally be used (including section 136 suites in adult settings, A&E, paediatric wards, local authority residential homes including children's homes, care homes, private homes of family or friends). CCGs will need to develop more flexible approaches which take account of local needs and context. However, children and young people are much more likely than adults to be turned away from places of safety. To help solve this staff in adult places of safety should have training to be able to support under 18 years and local protocols developed to ensure an end to locally imposed blanket bans on the use of section 136 suites for under 18-year-olds.

56. CQC could carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people in mental health crisis, which should include accessibility, responsiveness, quality of care and support for the young person and their family. Operational factors impacting on quality standards, such as environmental standards, staffing levels and training also require review. There also needs to be improved data on the availability of crisis treatment and the use of Section 136 for children and young people under 18, to support CCGs in their planning.

> *Case Study: Swift and comprehensive crisis care in County Durham*
>
> *Many children and young people have told us about their experiences of not being given access to mental health support until they have reached crisis point. However, many children and young people often don't know where to go when they do have a mental health crisis, especially outside the normal service hours of 9am-5pm, and for many the care they receive is often inappropriate to their needs. CAMHS in County Durham have developed their crisis care services, which runs alongside targeted services and pulls together a multi-agency plan for the child or young person until the crisis has passed. The crisis service is available 8am – 10pm, 7 days a week and offers 72 hour intensive support to between 8-10 young people at any one time. 24% of young people presenting with urgent mental health needs have been contained within 72 hours and introduced to appropriate support without needing to go above Tier 1.*

Access and waiting time standards

> *"I think the biggest issue when tackling mental health for any age is the waiting time, especially for young people because emotions and issues can change very quickly and sometimes the help is not there when you most need it."*
>
> *A young person who took part in the Taskforce engagement exercises*

57. The members of this Task and Finish group have proposed that to be effective, **all of the above proposals around improving access would need to be matched by sufficient commitment to provision of targeted and specialist services** that children and young people could be referred to where necessary. This would build on the vision and commitments in 'Achieving Better Access to Mental Health Services by 2020', (including the commitment that in 2015-16 more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral)**. Between 2015 and 2020 we need to see significant incremental, improvements in access and waiting times backed up by:**

a) A **prevalence target** to require an increasing proportion of children and young people with mental health needs to be treated. It will be crucial to design this so as to avoid perverse incentives to under identify/refer, including using local baselines.

b) **Access and waiting standards** based both on time taken from request for help and referral to assessment, and time taken to access evidence-based treatment. A number of partnerships participating in the CYP IAPT programme have already improved their

access by implementing the following response time-frames: emergency or crisis contact is responded to within a few hours; if urgent but not in crisis they will aim for first face-to-face contact within 1 week; for non-urgent referrals they will aim for a multiagency response or intervention to start within 4 to 6 weeks. Members of this Task and Finish group propose that children and young people should expect formal assessment and initiation of treatment within an appropriate timeframe based on individual risk and need, which achieves parity of esteem with waiting standards for physical health conditions.

c) This Task and Finish group suggests that widespread use of demand and capacity models (eg CAPA or LEAN), and implementation of CYP IAPT principles, could be useful in improving efficiency and minimising waiting times.

d) Children and young people and their parents/carers need some form of "holding response" whilst they are waiting. This can be as simple as the standardized formulation of a plan that indicates how long they can expect to wait, what is likely to happen once the wait has finished, being kept informed about progress towards appointment, and active signposting to resources they can access in the interim (including local support and digital resources).

e) **Sufficient funding to deliver the expansion of services needed** given that dealing with waiting times is reliant on services' resources and capacity to achieve this. This needs to be modelled and is subject to decisions by the next Government and the next spending review.

Good transitional care

"I've just turned 17 so it's my transition year, there's been no talk of it yet and I'm terrified about what's going to happen."

A young person who took part in the Taskforce engagement exercises

58. This Task and Finish group acknowledges that good transitional care is a key factor in children and young people's experience of mental health services. There are a wide range of possible transitions that may occur for any individual child or young person (eg NHS to VCS or vice versa, targeted to specialist or vice versa, CAMHS to adult mental health services) and these may occur as a result of changes in risk, need, situation, or age.

59. The engagement project carried out by YoungMinds for the Taskforce indicates that transition to adult mental health services is one type of transition viewed as being particularly difficult in the experiences of young people. As such, this Task and Finish group consider the obstacles posed by this type of transition to be of particular concern, and consider the need for the promotion of best practice principles to be of vital importance. In addition to ensuring that transitions take the form of best practice, further consideration should be given to the provision of services for young people up to the age of 25 years old, as is standard practice for many VCS YIACs.

60. The transition to adult services is subject to extreme local variation, with some young people making the transfer at 16, some at 16 if not in school or 18 if in school, and some at 18. All young people face multiple and often simultaneous transitions as they move to adulthood. This can be from school to higher or further education or work. They may be in the process of leaving home or care. Armed services families may be particularly affected by multiple moves. Young people transferring from children and young people's mental health services differ from those leaving physical services in that for many adult mental health services are either not available or not appropriate. Adult mental health services are not universally

equipped to meet the needs of young people with conditions such as ADHD, or mild to moderate learning difficulties or autistic spectrum disorder.

61. For some young people, the nature of adult mental health services and their emphasis on working with the individual rather than a more holistic approach including the family means that young people prematurely disappear from services altogether despite needing further support .

62. Youth Information Advice and Counselling Services (YIACs) usually operate over the age of transition, often up to the age of 25. We also note that in some parts of the country, such as Birmingham and Norfolk, there is a move to develop mental health services for 0-25 year olds. This new development will be watched with considerable interest.

63. The key components of best practice transition which are valued by both young people and clinicians should be built into Joint Strategic Needs Assessments (JSNAs), joint strategies for young people's and adult services and into all contracts between commissioners and providers of young people's and adult services. NHS England has published a model specification based on best practice for transitions and a transfer/discharge protocol that can be used by local areas to support better transition planning and delivery.

64. This Task and Finish Group does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care.

65. Vulnerable young people, such as care leavers and children in contact with the youth justice system, may also be especially vulnerable at points of transition and local strategic planning on transition should take their needs into account.

66. This Task and Finish group endorses the full implementation of NHS England's model specification for transitions from CAMHS to services for adults and discharge from and to other services during their care path[47] and proposes the promotion of best practice in transition from one service to another. Key components of best practice transition from CAMHS to services for adults that are valued by both young people and clinicians[48] [49] [50] include:

- Detailed operational protocols which promote person-centred planning and offer flexibility in decision-making.

- Flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age.

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[47] http://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf

[48] Joint Commissioning Panel for Mental Health (2012), Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services.

[49] Hovish, K., et al (2012), Transition Experiences of Mental Health Service Users, Parents, and Professionals in the United Kingdom: A Qualitative Study. Psychiatric Rehabilitation Journal 35(3).: 251-257

[50] McLaren, S. et al (2013). 'Talking a different language': an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. BMC Health Services Research, 13 (254).

- Gradual preparation and handover, initiated early and paced to the young person's needs, which includes transition planning meetings with staff from both services present.

- Continuity of care and periods of parallel care, including the opportunity for the young person to meet new service staff prior to transfer, consistency in key workers, and an agreement between services of shared responsibility for the young person.

- Joint working and shared practice between services, including joint posts, joint management meetings, shared training, use of compatible IT resources, and standardised approaches to record keeping and information transfer.

- Management in the context of the young person's other transitions that are happening at the time, such as continuing CAMHS support until a time when transition is less likely to clash with other changes, and facilitating access to a range of relevant services including education, employment and housing.

67. This Task and Finish group proposes that **these six components should be standard practice at any transition, built into JSNAs, and that all types of services work together locally to find the best way of implementing person-centred rather than service-centred transitions**. Whilst we have particularly focussed on the transition from CAMHS to other mental health services this is not the only type of transition experienced and there may be other transitions where the principles of good practice apply.

68. Examples of current good practice in transition include:

a) Leeds CAMHS, which has two dedicated transition workers who are responsible for robust transition planning over a period of around 6 months, which involves regular joint meetings with AMHS senior management to review the transitions protocol and shared monitoring of transferred cases through a formal 'Information Sharing Agreement'.

b) City and Hackney CAMHS, which have extended their service age boundaries to allow contact with the service to be maintained until the young person is fully engaged in adult services, rather than closing the case at the point of referral.

69. Members of this Task and Finish group acknowledge the difficulty of transitions on university students as having extra complexity due to geographical relocation and transience of residence. Students need access to mental health support both at home and at university, but are often precluded from one or the other depending on where they are permanently registered.

a) **Members of this Task and Finish group propose that NHS Trusts use digital resources and support systems to maintain support with students whilst they are not in the area**. NHS commissioners often aren't aware of how many students are in their area and where they are at different times of the year, so many do not take this into consideration when funding services.

b) **Members of this Task and Finish group support the production of best practice guidance for CCGs and GPs around student transitions** which encourages close liaison between the young person's home-based professional and university-based professional, and propose ensuring adherence to NHS guidelines on funding care for transient populations.

"My university GP was wonderful and made the effort to contact my GP at home, along with former services I had used for treatment, to get full information on my history of mental health problems…this is the experience that I think everyone should be having."

> *A young person who took part in the Taskforce engagement exercises*

Training to deliver improved prevention and access to support and evidence-based interventions

Training for professionals across sectors

70. Professionals who come into contact with children and young people provide the means to facilitate access to effective services, and need to be valued and supported in doing so. All professionals across health, education, social care, and the voluntary and community sector, as well as staff in other important sectors such as policing and youth justice, need to feel confident to promote good mental health and wellbeing and identify problems early. There needs to be sufficient growth in capacity to support system improvement.

71. Professionals need to be trained to be able to:

   - Recognise the **value** and **impact** of mental health in children and young people, and its **relevance** to their particular profession

   - **Promote** good mental health to children and young people

   - **Identify** mental health problems in children and young people, as well as those at particular risk of developing these problems

   - Offer appropriate preliminary support to children and young people with mental health problems

   - **Refer** appropriately to more targeted and specialist support

72. Children and young people identified in our engagement work that the communication skills of professionals are critically important to their experience of accessing, receiving, and engaging with mental health support – citing empathy, compassion, and listening skills as qualities they value, which are core elements of therapy training programmes[51]. All adults working with children, young people and their families can now access free practical e-learning sessions to support the development of these core skills at www.minded.org.uk Some of this Task and Finish group's members propose that MindEd e-learning sessions be blended with face-to-face training programmes for adults or professionals who work with children, young people and their families.

73. A core element of the CYP IAPT national curriculum is dedicated to core competencies for working with children, young people, parents and carers, and covers essential communication skills and engagement skills for this group. To ensure that more professionals are sufficiently equipped with the communication and engagement skills that children and young people and families so value, this Task and Finish group proposes the continuation and expansion of the CYP IAPT service transformation programme, and consideration of adapting this module of the CYP IAPT curriculum for professionals who are

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[51] YoungMinds (2014) Report on Children, Young People and Family Engagement for The Children and Young People's Mental Health Taskforce

not primarily responsible for treating mental illness in children and young people but nonetheless come into regular contact with them.

74. Leadership is vital, across all services and sectors, for promoting a shared vision of supporting children and young people's mental health and emotional wellbeing and for facilitating engagement of both individual staff and whole organisations. The CYP IAPT programme offers a service transformational leadership course to service leads across CAMHS, LA and the voluntary sector – members of this Task and Finish group suggest that this course be made available and, if necessary, adapted to be offered to a wider range of relevant professionals and organisations.

Training in assessment and formulation for mental health professionals

75. It is essential that there is an accurate assessment and formulation of a child's difficulties and/or goals for treatment at the beginning of any mental health intervention. If these are not assessed by people who know about the full range of childhood mental health problems then they may be addressed inappropriately at the beginning. This is not only a missed opportunity but can be positively harmful. An example of this would be treating a child for social anxiety or anger problems when they may be on the autistic spectrum and thus needing both diagnosis and a different approach. All mental health professionals therefore need adequate training in assessment procedures, as well as knowledge of local resources, to ensure that children and young people are offered the intervention most suited to their needs

Training for doctors and nurses

76. **Nurses** are the largest professional group within specialist CAMHS, accounting for 23% of the workforce[52]. In addition there are an estimated 15,000 children's nurses and 2,000 school nurses who come into contact with children and young people in universal services such as schools and GP surgeries. Children and young people have acknowledged the nursing profession as having as a key role in their experience of accessing mental health support[53]. Various professionals across different sectors have also identified nurses as having unharnessed potential within this context. However, child mental health does not form a significant part of either child branch training or mental health branch pre-registration training for most nurses. Neither are there any specific post-registration training or workforce development opportunities in child and adolescent mental health for nurses. Many nurses have received training in specific therapy interventions through the CYP IAPT programme, however there are limited opportunities for nurses who want to improve their nursing skills to receive further training

77. The role of the **GP** is central in the identification and management of the needs of children and young people experiencing mental health problems. However, results from a recent RCGP survey show that many GPs lack confidence in managing this group of patients. The revised foundation programme curriculum (available in early 2015) will give increased prominence to mental health, and 45% of foundation trainees will rotate through a psychiatry post during their first two years from 2016 to ensure that more junior doctors (50% of whom will become GPs) have experience of working with patients with mental health issues,

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[52] CAMHS Mapping (2009)

[53] YoungMinds (2014) Report on Children, Young People and Family Engagement for The Children and Young People's Mental Health Taskforce

including children and young people. However, attachments in psychiatry and other mental health related posts for Foundation Doctors and GP Trainees may still not enable sufficient contact with children and adolescents for them to gain confidence with this group of patients.

78. Staff in **paediatric services** make an important contribution to targeted and specialist mental health services for children and young people. The increased risk of developing a mental health problem in children and young people with physical illnesses and long term conditions, the overlap between medically unexplained symptoms and mental health problems, and the increasing numbers of hospital admissions of young people who have self-harmed, all mean that hospital-based paediatricians have daily contact with children and young people with mental health problems. Emotional and behaviour problems are a leading reason for referral to community paediatric services, a long-term trend that has continued to increase over the past three years. Community-based paediatricians play a leading role in the assessment and treatment of children and young people with neurodevelopmental disorders as well as playing a key role in the safeguarding and health of Looked After Children. As such, there is substantial overlap between their work and that of community CAMHS. Their role in the mental health of children and young people is likely to increase with a move towards greater integration between children's mental health provision and community paediatrics.

79. Limited CAMHS resources means that the number and complexity of mental health cases managed by paediatrics has greatly increased over recent years. However, lack of relevant training opportunities and organisational change leading to loss of liaison with CAMHS can often limit the effectiveness of paediatric management. Members of this Task and Finish group support the Paediatric Mental Health Association's recommendation to the Health Select Committee that the increasing emotional and behavioural presentations in paediatric practice be reflected in mandatory training for paediatricians in relevant aspects of mental health, and that the RCPCH appoint an dedicated officer for mental health to oversee training and policy issues in this area.

80. This Task and Finish group considers that we need to address the content and format of initial training, post-registration training, and CPD for nurses, GPs, and paediatricians, and make the following proposals:

   a) **HEE and individual Higher Education Institutes should look at developing pre- and post-registration training opportunities for nurses** working in both community and acute settings, such as considering the reinstatement of CAMH module ENB603 or the adaptation of CYP IAPT curricula modules. Increased emphasis needs to be made on emotional and behavioural development in basic training for child branch nurses. Likewise, CAMH-specific training needs to be strengthened for mental health branch nurses.

   b) **HEE should work with the RCPsych, RCGP, and RCPCH to look at how Foundation Doctors, trainee GPs and trainee paediatricians undertaking attachments in psychiatry and other mental health related posts can get meaningful exposure to child and adolescent mental health,** as well as perinatal mental health in the case of GP trainees, by reviewing and updating training programmes and activities.

   c) Enabling trainees to gain exposure to mental health in community and practice settings is likely to be more useful to them than specialised psychiatry for increasing their competence and confidence in detecting and managing mental health problems within the context of primary care, and referring appropriately for specialist input. As such, **the remit of psychiatry placements for Foundation Doctors and GP trainees should be broadened to allow exposure outside of secondary care, such as within the**

community and the voluntary sector. Flexibility in terms of format (eg 1 day a week for 12 weeks), as well as in content and context, could be considered.

d) **HEE and training providers should introduce and promote new models of integrated training**, such as shared speciality-led training between GP trainees, psychiatry trainees, and paediatric trainees. Existing models (such as UCLPartners' "Learning Together", which facilitates improved inter-speciality working between paediatric registrars and GP registrars) could be expanded to include child and adolescent mental health. Shared training programmes could also prove to be effective for nurses and good examples already exist which could be rolled out more widely.

Training for professionals in education settings

"I think schools need to do more…that has to start with the teachers so I would definitely advocate more mental health training for teachers in school so that they can understand our needs."

A young person

81. In education, from early years settings and primary schools through to secondary schools and colleges, the members of this Task and Finish group believe that we need to address **core content of initial training and quality/focus of CPD.**

82. There is a widespread perception amongst teachers in England that, although they believe they have a duty to help identify and support pupils with mental health problems, they feel inadequately prepared to do so[54].

83. The Carter Review of Initial Teacher Training reported in January. It recommended commissioning a sector body to produce a framework of core content for ITT which would include child and adolescent development. This fits with suggestions from members of this Task and Finish group that initial teacher training should explicitly address:

- How child development relates to emotional resilience and mental health
- Identifying signs and symptoms of mental health problems in children and young people
- When and how to refer appropriately to more specialist support.

84. MindEd offers accessible, freely-available e-training on a wide range of mental health issues in children and young people, with modular pathways for specific professional groups either established or able to be developed. Some members of this Task and Finish group suggest that the value of MindEd would be best optimised if supplemented with offline support and follow-up consultation and supervision, to ensure it is properly understood and safely used by those without a core training in mental health, and propose that it be resourced to develop blended learning and a 1 day face-to-face CPD course for teachers to fit in with inset days.

Training for professionals in social care

85. Social care professionals form a vital part of the skilled workforce in children's mental health services and bring specialist knowledge of vulnerable groups. They have a key role to play

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[54] Rothi, D.M., Leavey, G. & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. Teaching and Teacher Education, 24(5), 1217-1231.

in identifying and supporting the multiple needs (which often includes mental health needs) of many vulnerable children, young people and families.

86. The social work reform programme is placing a much stronger focus on the skills and competencies needed by children's social workers, including the ability to identify and refer children who may have mental health problems. This Task and Finish group support further roll out of the CYP IAPT curriculum to train social care professionals in evidence-based practice.

Training for the voluntary and community sector

87. Voluntary sector agencies employ a wide range of staff from highly trained and qualified staff to volunteers just entering the job market. It has been estimated that approximately 100,000 young people participate in counselling in the voluntary and community sector every year[55]. In addition, children and young people can also come into regular contact with a wide range of other voluntary and community workers. This includes sports coaches, youth advice workers, and leaders in youth clubs and organisations such as the Scouts and Brownies.

88. Providing VCS staff with the relevant knowledge and skills to either assess (in the case of counsellors) or notice when mental health problems may be present, and the ability to respond appropriately, could make an important difference to improving mental health in young people. Resources such as MindEd are available to support knowledge and skills acquisition in this area, but need wider promotion and development. The CYP IAPT training is available to staff working in the voluntary sector and more staff should be encouraged to build skills in specific evidence-based therapies to ensure children and young people have a choice of evidence-based interventions in different settings

A sustainable workforce strategy

89. We need to develop a sustainable **workforce strategy for staff within children and young people's mental health services** to ensure that enough staff have the right initial and continued skills to ensure person centred, evidence-based innovative approaches are used to deliver improved outcomes for children and young people. Services need to gain a better understanding of the challenges ahead and how they might develop a workforce that can meet the diverse needs of children, young people and families - both currently and in the future. Any strategic approach for defining a future workforce to best meet the diverse needs of the child and adolescent population would need to be backed up by a concerted drive to ensure that there will be sufficient staff to meet future demand and that they are equipped to fill the skills gaps that currently exist.

90. To support this, **this Task and Finish group proposes:**

a) The Department of Health, Department for Education, Health Education England, and the Chief Social Worker for Children to work together to design and commission census and needs assessment of the current workforce across the NHS, local authorities, youth justice, voluntary sectors and the independent sector as the first stage in determining a comprehensive cross-sector workforce and training strategy.

b) Health Education England and Local Education and Training Boards to establish local requirements through locally-led needs assessments of current workforce capacity and

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[55] Street, C. (2013). Voluntary and community sector (VCS) counselling provision for children, young people and young adults in England. Lutterworth: BACP/Counselling MindEd.

capability. This should include the collection of robust data on numbers, types, and skills of staff.

c) The continuation and expansion of the CYP IAPT service transformation programme to further embed the principles in existing services and extend to other children and young people's services and partner agencies in LAs and the voluntary sector.

d) The development and diversification of the CYP IAPT curricula to address gaps and deliver on other NICE-approved evidence-based interventions required to meet the mental health needs of children and young people currently not covered by CYP IAPT training programmes, particularly complex cases.

91. The workforce requires an expansion of staff. This applies to the numbers of staff employed as well as to the skills that they have. In addition to a sufficient level of training, a minimum standard of staffing is necessary in order to facilitate timely responses to children and young people seeking access and to allow sufficiently frequent appointments for therapeutic change to take effect. To meet growing demand, the current workforce needs to expand. This Task and Finish group suggest that the figures stipulated in the National Service Framework Chapter 9 (minimum 20 whole time equivalent practitioners per 100,000 total population) and subsequently re-iterated by the RCPsych[56] provide a starting point in terms of estimates. If services are to grow and develop, it is vital to recruit and retain good quality staff. With this in mind, some members of this Task and Finish group propose that consideration be given to addressing the difficulties in recruiting and retaining staff in mental health services:

a) HEE could give consideration to the need to increase the number of training places and posts for specialists in child and adolescent mental health.

b) Services, training providers and training accreditors could give consideration to the need to recruit and skill up a different pool of people. Many potential recruits could take on important roles and contribute greatly to children and young people's mental health, but may be deterred by the constraints of traditional entry requirements, learning formats, or professional roles.

c) Services could give consideration to how to address the difficulties in recruiting and retaining staff in mental health services. Currently, mental health is not seen as a particularly attractive area in which to work. We need to demonstrate that such a career choice will provide intellectual stimulus, good career opportunities, a fair rate of pay for the job and good working environment including flexible working and family friendly policies.

92. It is evident that the current workforce needs to expand if it is to meet growing demand. However, the reverse is actually happening: budget cuts and stretched resources mean that staff numbers are decreasing rather than increasing. As such, this Task and Finish group acknowledges that the staffing figures recommended above may not be achieved. The group therefore suggest that services consider reviewing current practice to ensure that the very best use is being made of the distinctive capabilities of the staff that they do have. It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered.

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[56] Royal College of Psychiatrists (2013), Building and Sustaining Specialist CAMHS.

Members of the Prevention and Access Task and Finish Group

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We would also like to thank the following people for their contributions to the report:

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Annex A: Relevant recommendations from Health Select Committee report, 5 November

CAMHS as a whole system

4. Whilst most attention has so far centred on problems in accessing inpatient treatment, compelling arguments have been made to this inquiry that the focus of investment in CAMHS should be on early intervention–providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to inpatient services. It is clearly unacceptable if a child or young person cannot access a Tier 4 service close to their home, but for every child in this position, a further question needs also to be asked - has everything possible been done to prevent that child from becoming so unwell that they needed admission to inpatient services? The evidence we have received suggests poor provision of lower tier services may be increasing the number of children and young people requiring admission to inpatient services. This situation must be addressed by the Taskforce. (Paragraph 33)

Early intervention mental health services (Tier 2)

5. We recommend that, given the importance of early intervention, the DH/NHS England taskforce should have an explicit remit to audit commissioning of early intervention services in local authorities, and to report on how best to improve incentives in this area. They should also look at the best mechanisms to provide stable, long term funding for early intervention services including those provided by voluntary sector partners**.** (Paragraph 51)

Outpatient specialist CAMHS services (Tier 3)

6. Whilst demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. CCGs have the power to determine their own local priorities, but we are concerned that insufficient priority is being given to children and young people's mental health. We recommend that NHS England and the Department of Health monitor and increase spending levels on CAMHS until we can be assured that CAMHS services in all areas are meeting an acceptable standard. We welcome recent funding announcements for mental health services but we remain concerned and recommend that our successor committee reviews progress in this area. (Paragraph 112)

Outpatient specialist CAMHS services (Tier 3)

8. We heard from witnesses that national service specifications are required, to set out minimum acceptable levels of community CAMHS services, and we understand that Tier 2 and 3 service specifications are now being developed. We recommend that these specifications should set out what reasonable services should be expected to provide. They should cover specific clinical areas including ASDs, perinatal mental health, and eating disorders, as well services which currently fall between the Tiers, including out-of-hours, outreach and paediatric liaison. We recommend that the taskforce should carry out and publish an audit of whether services are meeting these minimum standards. (Paragraph 116)

Outpatient specialist CAMHS services (Tier 3)

10. There is unacceptable variation in the provision of perinatal mental health services, and we recommend this is addressed urgently. Service specifications should make clear that these services must be available in every area. (Paragraph 120)

Inpatient CAMHS services (Tier 4)

11. It is wholly unacceptable that so many children and young people suffering a mental health crisis face detention under s136 of the Mental Health Act in police cells rather than in an appropriate place of safety. Such a situation would be unthinkable for children experiencing a crisis in their physical health because of a lack of an appropriate hospital bed and it should be regarded as a 'never event' for those in mental health crisis. In responding to this report we expect the Department of Health to be explicit in setting out how this practice will be eradicated. (Paragraph 160)

Inpatient CAMHS services (Tier 4)

14. We believe that education is crucial to protecting the life chances of the especially vulnerable young people who need inpatient treatment for mental health problems, particularly as in some cases these admissions may last many months. It is essential that clear standards are set for the quality of education provision in inpatient units, and that there is clear accountability and ownership for ensuring that these standards are upheld. As a first step towards this, we recommend that OFSTED, DFE and NHS England conduct a full audit of educational provision within inpatient units as a matter of urgency. (Paragraph 166)

Bridging the gap between inpatient and community services

15. It is clear from the evidence we have received that commissioning extra inpatient capacity alone will not be enough to alleviate the current problems being experienced in relation to Tier 4 services. Perverse incentives in the commissioning and funding arrangements for CAMHS need to be eliminated to ensure that commissioners invest in Tier 3.5 services which may have significant value in minimising the need for inpatient admission and in reducing length of stay. The Department of Health and NHS England must act urgently to ensure that by the end of this year all areas have clear mechanisms to access funding to develop such services in their local area, where this is appropriate.(Paragraph 188)

Schools

17. We consider that awareness of mental health issues, including their relationship to normal child development, conduct issues, and impact on education, is important and we recommend the Department for Education looks to including a mandatory module on mental health in initial teacher training, and should include mental health modules as part of ongoing professional development in schools for both teaching and support staff**. (Paragraph 210)

Schools

18. We recommend that the Department for Education conducts an audit of mental health provision and support within schools, looking at how well the guidance issued to schools this year has been implemented, what further support may be needed, and highlighting examples of best practice. OFSTED should also make routine assessments of mental health provision in **schools.** (Paragraph 211)

Schools

19. We recommend that the Department for Education consult with young people, including those with experience of mental health issues, to ensure mental health within the curriculum is developed in a way that best meets their needs. (Paragraph 212)

Annex B: School Counselling

1. Counselling is a mental health intervention that children or young people can voluntarily enter into if they want to explore, understand and overcome issues in their lives which may be causing them difficulty, distress and/or confusion. A counselling relationship has identified boundaries and an explicit contract agreed between the young person, counsellor and, where appropriate, parent or carer.

2. In secondary schools, most counselling is conducted on a one-to-one basis, and is generally based on "humanistic" principles. This is an approach that aims to provide young people with an opportunity to talk through their difficulties in an understanding and supportive environment, and to find their own ways of addressing their problems[57]. This type of talking therapy is in keeping with guidelines from NICE on appropriate interventions for children and young people experiencing mild depression. In primary schools, much of the counselling work incorporates non-directive play- or arts-based methods, but might also include family work or group work[58].

3. Schools will want to ensure that there are effective quality assurance frameworks in place so that they have a clear picture of the prevalence of issues and referrals, the impact of counselling on children and young people's outcomes, and ongoing assurance of the quality and professionalism of the counsellor. Commissioning an appropriately qualified and experienced external provider should give assurance to schools that the counsellor is properly trained, supported, clinically supervised, insured and working within agreed policy frameworks and standards, and accountable to a professional body with a clearly articulated complaints procedure. If employing counsellors directly it is strongly advised that schools employ staff with a minimum of a diploma in counselling, on an Approved Voluntary Register, ideally in possession of accreditation with one of the professional bodies (eg BAAT, BACP, UKCP) and relevant experience working with children and young people.

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[57] Cooper, M. (2013). School-based counselling in UK secondary schools: A review and critical evaluation. Lutterworth: BACP/Counselling MindEd

[58] Thompson, W. (2014). School-based counselling in UK primary schools. Lutterworth: BACP/Counselling MindEd.

Annex C: 10 Key Principles of a Single Point of Access Arrangement

1. *Collaborative across the system.* Sign up from all parties is essential. It should include targeted and specialist CAMHS, crisis care, paediatrics, primary care, social care, youth justice, education, local authorities, and VCS. All parties should be aware of each other and their respective roles, agree to work together, recognise the contribution of the other parties, and share information appropriately.

2. *Informed.* Local models must include calculation of demand and capacity using relevant data.

3. *Visible.* Points of contact should be clearly identifiable and well known to children and young people, their families, and the professionals that work with them.

4. *Universally available.* Reachable via universal services so children and young people do not have go through difficult processes to access them, or experience being seen as different. Contact should be additionally facilitated through drop-in sessions and self-referral routes.

5. *Timely.* An initial risk assessment should be completed straight away to ensure children and young people with risk issues are seen as a priority. A decision should be made promptly as to which service can best meet their needs. In order to ensure that sound judgements are made in good time, points of contact would need to be appropriately skilled and experienced in risk assessment and case formulation.

6. *Responsive.* Any contact point should be backed up by a response process and embedded within a clearly identified pathway beyond the initial contact, so that a point of contact becomes a point of genuine access. This requires points of contact to be supported by strong links to and relationships with all agencies involved.

7. *Transparent.* There should be clarity on what is and what is not available, as well as clarity on confidentiality and information-sharing.

8. *Bi-directional.* Points of contact should help children and young people with the transition out of targeted or specialist support as well as in to it.

9. *Flexible.* Points of contact should accommodate heterogeneity amongst those seeking help. This includes accommodating vulnerable children and young people, for whom referrals should not be based solely on clinical diagnosis but rather on the presenting needs of the individual and the level of distress or dysfunction. This also includes accommodating parents/carers, who may wish to initiate the help-seeking process when their child is too ill or scared to do so themselves.

10. *Validating.* All consultations requested, whether generating further referral or limited to a one-off visit, should be valued irrespective of their outcome. All consultations should be valued for their potential to provide children and young people with knowledge of their needs and choice of options.

Annex D: Glossary

AMHS	Adult Mental Health Services
BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CAPA	Care and Partnership Approach
CBT	Cognitive Behavioural Therapy
CPD	Continuing Professional Development
CQC	Care Quality Commission
CYP IAPT	Children and Young People's Improving Access to Psychological Therapies
CCGs	Clinical Commissioning Groups. Statutory bodies clinically led that include all of the GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to take commissioning decisions for their patients. CCGs are overseen by NHS England (including its Regional Offices and Area Teams). Each CCG has a constitution and is run by its governing body.
DfE	Department for Education
DH	Department of Health
HCP	Healthy Child Programme
HEE	Health Education England
ITT	Initial Teacher Training
JSNA	Joint Strategic Needs Assessment Process of reviewing and describing the current and future health and wellbeing needs of a local population
LAs	Local Authorities
NICE	National Institute for Health and Care Excellence
OFSTED	Office for Standards in Education, Children's Services and Skills
PHE	Public Health England
PSHE	Personal, Social and Health Education

QNIC	Quality Network for Inpatient CAMHS
RCGP	Royal College of General Practitioners
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists
Section 136	Section of the Mental Health Act which allows a police constable to remove a person appearing to be suffering from a mental disorder from a public place to a place of safety for up to 72 hours for the purposes of making arrangements for assessment, treatment or care
SEND	Special Educational Needs and Disabilities
Tier 1	Consists of non-specialist primary care workers such as school nurses and health visitors. Treatment is provided for common problems of childhood (e.g sleeping difficulties or feeding problems) as well as referral to more specialist services.
Tier 2	Consists of specialised primary mental health workers such as psychologists, counsellors, and mental health nurses.
Tier 3	Consists of specialist multidisciplinary professionals working together such as psychiatrists, social workers, educational psychologists, and occupational therapists.
Tier 4	Consists of specialised outpatient services, and day and inpatient units, where patients with more severe mental health problems (eg life-threatening eating disorder) can be assessed and treated.
VCS	Voluntary and Community Sector
YIACS	Youth Information, Advice and Counselling and Support Services